COMMENTS OF
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SUBMITTED TO THE
OFFICE OF HEALTH STRATEGY

PRELIMINARY RECOMMENDATIONS OF
THE COST GROWTH BENCHMARK TECHNICAL TEAM

On behalf of Trinity Health Of New England, please accept the below comments to the Office of Health Strategy's (OHS) Preliminary Recommendations of the Healthcare Cost Growth Benchmark (CGB) Technical Team (Preliminary Recommendations). We appreciate the opportunity to comment on the Preliminary Recommendations and look forward to continuing to work with your office as it continues to implement the requirements of Executive Order No. 5 (EO 5).

Trinity Health Of New England is committed to sustaining and improving access to high quality healthcare services in the communities we serve. We appreciate that affordability is central to that commitment and as such, we believe that statewide coalescence around a more sustainable growth rate for healthcare expenditures can be an important opportunity to alter the trajectory of healthcare spending in our state.

Specific to the Preliminary Recommendations, we offer the following comments.

Healthcare Cost Growth Benchmark

Annual Spending Target

In setting the annual spending targets, it is imperative that they appropriately reflect and promote healthcare's important role in the state's economy.

Trinity Health Of New England includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital in Hartford; Saint Mary's Hospital in Waterbury; and Johnson Memorial Hospital in Stafford Springs. In addition, our ministry includes physician practices and an ambulatory services network. We are 12,000 colleagues and health care providers committed to being a transforming and healing presence in the communities we serve. Our hospitals provide more than 265,000 emergency department visits, 40,000 surgeries and 5,000 births annually. We do more than treat illness and injury. We are helping to build a healthier Connecticut by improving community health, managing chronic

illness, expanding access to primary care, preparing for emergencies and addressing social influencers of health.

As the nation and our state dig out of a severe economic downturn, the healthcare sector is going to be an essential part of that recovery.

Unfortunately, the recommendation of the Technical Team undervalues this important role. The recommended benchmark ratio does not appropriately value the healthcare sector's importance to the economy and puts our state's economic recovery at risk. It also dramatically diverges from our neighboring states, Massachusetts and Rhode Island, which have implemented targets successfully and pegged their target rates to potential gross state product (PGSP).

The target rate that results from the use of the benchmark ratio, 2.9 percent, is inappropriately low. Only after manual adjustment of the target rates in 2021 (3.4 percent) and 2022 (3.1 percent) do the rates come in closer alignment to an appropriate target rate. However, the rates recommended for 2023, 2024, and 2025 (2.9 percent) benefit from no such adjustment and fall well short of being appropriate.

We recommend that OHS reject the benchmark targets presented in the Preliminary Recommendation and instead adopt target rates derived from a ratio set at 90 percent PGSP and 10 percent median household income.

<u>COVID-19</u>

As was described in a June letter from the Connecticut Hospital Association (CHA) to the Governor, since the time the Governor signed EO 5 in January, the COVID-19 pandemic has markedly changed the state's healthcare landscape. Among the pandemic's most profound effects has been a marked reduction in access to and use of medically necessary healthcare services, of all types and in all settings, with consequences for the public's health that are not yet fully understood.

COVID-19 preparedness efforts at Trinity Health Of New England were and continue to be extremely resource intensive. Our hospitals have responded to this pandemic by adding beds, redesigning emergency departments and patient flow, purchasing tremendous amounts of supplies and equipment, implementing new processes to address regulatory changes and new reporting requirements, and testing colleagues for the virus and paying for at-home quarantines. We also augmented our community-based public health infrastructure to focus on COVID education and development of a robust community testing program focused on underserved neighborhoods. As good financial stewards, we engaged in efforts to reduce our costs. These efforts included a capital freeze, workforce and salary reductions, and delaying strategic initiatives. At the same time, elective surgeries and other procedures, were largely stopped, this past Spring. While inpatient, outpatient emergency department utilization has rebounded, it is still not back to pre-COVID levels.

Given these circumstances, it is essential for OHS to outline specifically how it will address the consequences of COVID-19 in its implementation of the benchmark. This critical issue has not been given appropriate public consideration to this point.

As we have seen in other states, cost growth benchmarks are designed to be durable enough to accommodate unpredictable, one-time spending irregularities. However, that durability is built off a well-understood and data-backed cost and utilization base period.

It is incumbent, therefore, that as Connecticut's process for building the benchmark continues, there is explicit instruction to detail the steps that will be taken to account for the anomalous situation that COVID-19 has created, seek stakeholder feedback on those steps, and incorporate them in the final product.

Implementation

We appreciate OHS's work to include stakeholders in the implementation of EO 5, including the inclusion of hospital and health system representatives on the Stakeholder Advisory Board. In keeping with an open and transparent process, we encourage OHS to take further steps to obtain additional public comment and feedback, most specifically as it develops implementation guidance.

There are a number of critical, outstanding questions that deserve public review, scrutiny and comment. Among those that deserve additional specificity:

- Implementation of the assessment and evaluation process,
- Defining the parameters, including excepted spending, by which measurement of performance against the benchmark will be determined, and
- Appropriate protections for data and information submitted and used for benchmark purposes.

Primary Care Spending Targets

EO 5 requires ten percent of total spending to be attributed to primary care by 2025. OHS sets forth a central aim of using the increased investment to promote **advanced primary care**. If the definition adopted for the purpose of meeting the target does not include the components of advanced primary care, payers will focus on investments that fall within a narrower definition.

Unfortunately, the Preliminary Recommendations takes an overly narrow view of the types of providers and services that should be counted for purposes of meeting the target. **At a minimum, the definition should include integrated behavioral health, which is widely viewed as an essential element of advanced primary care by the National Alliance of Healthcare Purchaser Coalitions, Patient Centered Primary Care Collaborative, and the OHS Practice Transformation Task Force.**

The use of a definition consistent with the above recommendations will spur investments in advanced primary care that are aligned with this definition and it will enable better quality care, better healthcare outcomes, and reductions in avoidable use and associated costs.

We look forward to remaining engaged in the process to implement the CGB, appreciate the opportunity to comment on the Preliminary Recommendations, and look forward to additional opportunities to provide comment on CGB implementation guidance.